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Office of Administrative Law Judges
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Issue Date: 24 August 2005

In the Matter of:

HORACE M. PYLES,
Claimant

Case No.: 2003-BLA-6562

v.

JORDAN BROTHERS COAL,
Employer

and

ROCKWOOD INSURANCE CO.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Ron Carson, Program Director
Stone Mountain Health Services
St. Charles, Virginia
For the Claimant

Timothy W. Gresham, Esq.
Penn Stuart
Abingdon, Virginia
For the Employer/Carrier

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING REQUEST FOR MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and

727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2005). In this case, the Claimant, Horace M. Pyles, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on January 14, 2004, in Knoxville, Tennessee. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2005). At the hearing, the Claimant was the only witness. Director's Exhibits ("DX") 1-32, Claimant's Exhibits ("CX") 1-6 and Employer's Exhibits ("EX") 1-11 were admitted into evidence without objection.[1] Transcript ("TR") at 5-The record was held open to allow the Claimant to submit Dr. Alexander's rereading of the chest x-ray dated October 20, 2003, which was submitted under cover of letter dated January 24, 2004, and is admitted into evidence as CX 7. TR 10-11, 23-24. In addition, I have received and considered the Employer's Closing Argument, which was submitted under cover of letter dated March 22, 2004. The Claimant's lay representative provided an oral closing argument at the end of the hearing. TR 24-25. The record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits admitted into evidence, the testimony presented, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on February 12, 1987. The claim was denied by Administrative Law Judge E. Earl Thomas, who found that the Claimant had pneumoconiosis, but was not totally disabled. Following the Claimant's timely appeal, the Benefits Review Board issued a Decision and Order dated November 23, 1990, affirming Judge Thomas' Decision and Order Denying Benefits. The Claimant did not appeal that determination. DX 1.

More than one year later, on February 20, 2001, the Claimant filed a subsequent claim, which was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on March 13, 2002. The District Director found that the evidence did not show that

[1] Initially counsel for the Employer objected that the Claimant had exceeded the limitations on medical evidence contained in the regulations by submitting two readings of the x-ray dated April 8, 2002. Upon further discussion, however, the parties agreed to waive their objections to multiple readings of x-ray films. TR 7-8. After the hearing, however, the Benefits Review Board held that the limits are mandatory and cannot be waived by the parties, and the parties must show good cause for admission of medical evidence in excess of the limitations. *Smith v. Martin County Coal Corp.*, 23 B.L.R. 1-69 (2004). On April 7, 2005, I issued an order to the parties to confer regarding the exhibits. After conferring, the parties advised that the x-ray readings did not exceed the limits, and the Employer withdrew EX 4, an extra pulmonary function test. *See* letter dated April 18, 2005.

the Claimant had pneumoconiosis, or that it was caused by coal mine work, or that the Claimant was totally disabled.

Less than one year later, on March 12, 2003, the Claimant filed his current request for modification. DX 21. The Director issued a proposed Decision and Order denying modification on June 17, 2003. DX 25. The Claimant appealed on July 14, 2003. DX 26. The claim was referred to the Office of Administrative Law Judges for hearing on August 26, 2003. DX 29.

APPLICABLE STANDARDS

This case pertains to a request for modification of an adverse decision rendered on a "subsequent" claim filed on February 20, 2001, after the effective date of the current regulations. For this reason, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2005). Pursuant to 20 CFR § 725.310 (2005), in order to establish that he is entitled to benefits, the Claimant must demonstrate that there has been a change in conditions or a mistake in determination of fact such that he meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2005). Where modification is sought based on an alleged change in conditions, new evidence must be submitted and the administrative law judge must conduct an independent assessment of the newly submitted evidence, in conjunction with the evidence previously submitted, to determine whether the weight of the evidence is sufficient to establish the element or elements which defeated entitlement in the prior decision. *Napier v. Director, OWCP*, 17 BLR 1-111, 1-113 (1993); *Kovac v. BCNR Mining Corp.*, 14 BLR 1-156, 1-158 (1990), *modified on recon.*, 16 BLR 1-71 (1992). Where modification is sought based upon a mistake of fact, new evidence is not a prerequisite, and the adjudicator may resolve the issue based upon "wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971); *Kovac v. BCNR Mining Shipyards, Inc.*, 16 BLR 1-71, 1-73 (1992), *modifying* 14 BLR 1-156 (1990).

Because the underlying claim is a subsequent claim, pursuant to 20 CFR § 725.309(d) (2005), in order to establish that he is entitled to benefits, the Claimant must also demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final." I must consider the new evidence and determine whether the has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

For the reasons explained below, I have found that the Claimant has established a change in conditions since his initial claim was denied because pulmonary function tests now demonstrate that he is totally disabled by a pulmonary impairment. Therefore, I must address all of the medical evidence from both claims in this decision. Evidence admitted in the prior claim may be considered notwithstanding the limitations on the introduction of evidence contained in 20 CFR § 725.414 (2005). 20 CFR § 725.309(d)(1) (2005). Moreover, no findings in the prior

claim are binding, unless a party fails to contest an issue, or made a stipulation in a prior claim. 20 CFR § 725.309(d)(4) (2005). In this case, although there was a finding that the Claimant had pneumoconiosis in the decision on his initial claim, the Employer never made a stipulation to that effect, and it is contesting that issue in this proceeding.

ISSUES

The issues contested by the Employer and the Director are:

1. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

5. Whether the evidence establishes a material change in conditions since denial of his initial claim pursuant to 20 CFR §725.309.

6. Whether the evidence establishes a change in conditions and/or that a mistake was made in the determination of any fact in the prior denial of the current claim pursuant to 20 CFR §725.310.

The Employer also challenged the validity and applicability of the new regulations to preserve the issue for the purpose of appeal; all other issues it raised before the District Director (timeliness, whether the Claimant was a miner, and how long he worked as a miner) were withdrawn. DX 29; TR 5.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant, Horace M. Pyles, was born in 1930. He has no dependents for the purpose of potential augmentation of benefits under the Act. DX 3, 29; TR 13.

Length of Coal Mine Employment

On the current application, the Claimant alleged that he worked in or around coal mines for 25 years ending in 1986. DX 3. On his initial application, he claimed 22 years of coal mine employment ending on May 12, 1986. DX 1. At the hearing, the Claimant testified that he engaged in coal mine employment for "about 30 years," but that he was credited with "23 on paper." TR 14. The Employer conceded that the Claimant engaged in coal mine employment for 23 years, DX 29, which is consistent with Judge Thomas' finding, as set forth in his Decision and Order Denying Benefits, dated November 23, 1988. DX 1. In view of the foregoing, I find that the Claimant has established *at least* 23 years of coal mine employment.

Moreover, the discrepancies in the Claimant's exact coal mine employment history, as described above, are inconsequential for the purpose of rendering a decision.

Responsible Operator

The Employer, Jordan Brothers Coal, stipulated, and I find, that it is the properly designated responsible operator. DX 1, 4, 29.

Last Usual Coal Mine Employment

The Claimant's last usual coal mine job was as a coal processor at the tipple, outside the coal mines, where the coal was hauled, crushed, and separated. The Claimant testified that the job required considerable physical exertion, including shoveling coal, cleaning the belts, picking rock, and running the tipple. He estimated that he picked up 50 to 60 pounds with the shovel, and that he shoveled the clog off the belt about 1 to 1 ½ hours each eight-hour shift. In addition, the Claimant periodically fixed the tipple and carried an 80 or 90-pound oxygen tank up one flight of stairs by himself. Furthermore, the Claimant stated that the job entailed a lot of bending. TR 15-17.

Although the coal tipple was outside the mine, TR 15, the Claimant stated that it was a dusty job. However, the Claimant acknowledged that he wore a respirator at the tipple every day. Furthermore, only 5 out of his 23+ years coal mine employment was spent in underground coal mines. TR 17.

His last coal mine employment was in Tennessee. TR 20. Therefore this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Smoking History

At the hearing, the Claimant testified that he never smoked. TR 19. At the prior hearing held on April 12, 1988, the Claimant stated that he was not a "regular habit smoker," but that he had smoked about four or five cigars per year. Transcript of the April 12, 1988, hearing at 25, DX 1. Taken as a whole, I find that the Claimant's smoking history is negligible.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis."

A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2005). An X-ray interpretation which made no reference to pneumoconiosis, positive or negative, given in connection with review of an x-ray film solely to determine its quality, is listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and/or the registry of physicians' specialties maintained by the American Board of Medical Specialties.[2] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

The following table summarizes the x-ray findings available in the subsequent claim.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
06/12/01	CX 2 Ahmed (BCR, B) 1/1	DX 11 Hudson (A)	DX 11 Sargent (BCR, B) Read for quality only – film quality 1

[2]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004, found at http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www2a.cdc.gov/drds/breaders/breaders_results.asp. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
11/02/01	CX 3 Cappiello (BCR, B) 1/1	EX 1 Dahhan (B)	
04/08/02	CX 1 Ahmed (BCR, B) 1/1 DX 23 Pathak (BCR, [3] B) 1/2	EX 6 Scott (BCR, B) EX 7 Scatarige (BCR, B)	
10/20/03	CX 7 Alexander (BCR, B) 1/2	EX 10 Wheeler (BCR, B)	

X-ray interpretations from the prior claim appear on the following chart:

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
02/25/87	DX 1 (DX 12) (DX 13) Cohen (BCR) unclassified[4]	DX 1 (DX 10) Elmer (BCR, B) DX 1 (DX 11) Cole (BCR, B) DX 1 (DX 27B) Wheeler (BCR, B) DX 1 (DX 27B) Scott (BCR, B)	
01/11/88	DX 1 (CX 2) Cohen (BCR) unclassified[5]	DX 1 (EX 11) Wiot (BCR, B) DX 1 (EX 12) Spitz (BCR, B)	
03/07/88		DX 1 (EX 3) Hudson 0/0 DX 1 (EX 7) Scott (BCR, B) DX 1 (EX 6) Wheeler (BCR, B)	

[3] Board certified in the United Kingdom. *See Hendrix v. Jim Walter Resources*, *Inc.*, BRB No. 99-1332 BLA (Nov. 30, 2000) (unpub.).

[4] Dr. Cohen's impression stated in pertinent part, "… Chronic bilateral pleural thickening, more marked on the right. Although this finding is non-specific, the degree of pleural thickening present raises the possibility of occupational lung disease (asbestosis or pneumoconiosis). Chest film otherwise normal."

[5] Dr. Cohen's impression stated, "Chronic bilateral pleural thickening, more marked on the right. This finding, though non-specific, raises the possibility of occupational lung disease, such as asbestosis or pneumoconiosis. Chest film otherwise essentially normal."

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in connection with the subsequent claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2005).

Ex. No. Date Physician	Age Height[6]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
EX 9 08/13/90 Poteet	60 66"	2.31 2.58	3.27 3.59	70.6% 71.9%	61 69	No	Mild obstructive pattern.
DX 11 06/12/01 Hudson	71 66"	1.03	1.57	65.6%	33	Yes	Acceptable except for suboptimal MVV performance per Dr. Michos
EX 1 11/02/01 Dahhan	71 165cm	.81 .94	1.28 1.3	64% 71%	20 19	Yes	
DX 21, CX 5 12/13/01 Narayanan	71 66"	.82	1.42	57.7%	27	Yes	Severe obstruction. Not valid per Dr. Long, EX 5.

[6] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 65" to 67", I have taken the mid-point (66") in determining whether the studies qualify to show disability under the regulations.

Ex. No. Date Physician	Age Height[6]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
CX 4 10/20/03 Narayanan	73 66”	.85	1.26	67%	24	Yes	Severe obstruction. Not valid per Dr. Long, EX 11.
EX 10 10/20/03 Dahhan	73 165cm	.80 .95	1.21 1.39	66% 68%	21 16	Yes	

The following chart summarizes the results of the pulmonary function studies available inc connection with the prior claim.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 1 (DX 7) 02/25/87 Seargeant	56 66 ½”	2.12	3.22	65.8%	47.1	No	Partially invalid per Dr. Long, DX 1 (EX 8). Completely invalid per Dr. Fino, DX 1 (EX 9)
DX 1 (EX 4) 03/07/88 Hudson	57 67”	2.60	3.48	74%	59	No	Small airways obstruction. Suboptimal effort.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in connection with the subsequent claim. A “qualifying” arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered.

Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2005).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 11	06/12/01	Hudson	40.2 40.4	73.0 86.0	No No	
EX 1	11/02/01	Dahhan	47.1	72.8	No	Normal.
EX 10	10/20/03	Dahhan	44.8	67.5	No	Mild hypoxemia.

The following chart summarizes the arterial blood gas studies available in connection with the prior claim.

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 1 (DX 9)	02/25/87	Sergeant	38 33	74 84	No No	
DX 1 (EX 5)	03/07/88	Hudson	38.8	71.5	No	Mild hypoxemia.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2005). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2005). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2005). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2005).

The case file includes the medical opinions and/or office notes of Drs. Poteet, EX 8, Toyohara, EX 3, Hudson, EX 2, DX 11, Isber, DX 24, Dahhan, EX 1, 10, Seargeant, DX 24, and

Kellie Brooks, a Family Nurse Practitioner, CX 6, which were submitted in connection with the current, subsequent claim, as summarized below.

Dr. Tony Poteet examined the Claimant on August 14, 1990. EX 8. Dr. Poteet set forth the Claimant's chief complaint that he "can't breathe good"; a history of his present illness, past medical history, social history, review of systems, findings on physical examination, and diagnostic data, including a chest x-ray and pulmonary function test. In summary, Dr. Poteet reported a negative cigarette smoking history and noted that the Claimant "has been a coal miner in the past," without specifying the length of such employment. Dr. Poteet found "a few crackles at the bases of the lungs," but "no rhonchi or rales were noted." Dr. Poteet's handwritten notes listed the Claimant's height and weight as 65 ½" and 252 lbs., respectively. Furthermore, the accompanying medical assessment indicated that Dr. Poteet related the Claimant's shortness of breath to obesity. On the typewritten report, Dr. Poteet stated that the chest x-ray revealed old scarring at the bases, but no active disease. Pulmonary function testing showed "a mild obstructive pattern with the patient achieving about 80% or better of his predicted forced vital capacity." In conclusion, Dr. Poteet stated, in pertinent part: "ASSESSMENT: 1. Morbid obesity. Associated with his complaint of shortness of breath, paroxysmal nocturnal dyspnea and orthopnea, I could suggest Pickwickian syndrome with some sleep apnea. This might be further evaluated by sleep studies." EX 8.

Dr. Hiroshi Toyohara examined the Claimant on December 8, 1999, in consultation, "to evaluate for possible coronary artery bypass grafting." EX 3. On examination, the Claimant was described as a "well-developed, obese male who is in no acute distress." The Claimant's past medical history included a "left facial stroke in his 30s" with residual paralysis therein. In addition, the Claimant said he had a "throat stroke" in 1992, and that he couldn't speak for a few days. Dr. Toyohara described the history of the Claimant's present (*i.e.,* heart-related) illness as follows:

> This is a 69-year-old male who has had no history of heart disease until a few days ago when he had acute myocardial infarction complicated by supraventricular tachycardia and congestive heart failure. Initially, he was treated at Lafollette Medical Center and transferred here for further evaluation and treatment. The cardiac catheterization done by Dr. Towne today revealed total occluded proximal RCA which appeared to be non-dominant. The RV branch had a 60% take-off lesion. There is 80% stenosis over the distal left main. There was an 80% take-off lesion of the LAD. There were 50% and 30% lesions in the distal circumflex coronary artery. The ejection fraction was 15-20% with anterior and apical akinesia.

EX 3.

Dr. Arnold R. Hudson, a pulmonologist (DX1 (EX 10)) examined the Claimant on December 9, 1999, in consultation, to provide a "preoperative pulmonary evaluation." EX 2. Dr. Hudson summarized the findings regarding the Claimant's cardiac condition. In the introductory part of the report, Dr. Hudson noted that the Claimant had never smoked, nor been diagnosed with chronic lung disease, nor been hospitalized for shortness of breath. Furthermore, Dr. Hudson stated: "He worked in the coal mines for many years, and was turned down for his

black lung application which leads me to believe that his pulmonary functions must have been fairly good at the time of the application." In addition, Dr. Hudson set forth the Claimant's negative smoking history, a coal mine employment history of 30 years, review of systems, and findings on physical examination. The latter included the following: "Chest: Limited expansion of chest wall, probably the combination of less than enthusiastic effort by patient and his obesity. Normal to percussion and palpation. No focal rales or wheezes." Clinical tests included a chest x-ray and EKG. The x-ray reportedly showed "right pleural effusion." The EKG showed "atrial fibrillation with left bundle branch block." In summary, Dr. Hudson set forth the following impressions and recommendations:

> IMPRESSION
> 1. Suspect dyspnea, mostly cardiac in origin.
> 2. Severe restriction by bedside spirometry, but suspect this overestimates degree of restriction due to a combination of patient's debilitated state from his recent acute myocardial infarction, and perhaps some misunderstanding of the vigor with which he was supposed to perform the task.
> 3. Arteriosclerotic heart disease with acute myocardial infarction on admission, with atrial fibrillation and cath showing severe multivessel coronary disease, including a critical left main lesion.
> 4. Renal insufficiency.
> 5. Morbid obesity.
> 6. Suspect obstructive sleep apnea.
> 7. History of cerebrovascular accident without major residual impairment.
>
> DISCUSSION AND RECOMMENDATIONS: I have requested ABGs on room air, PA and lateral chest x-ray, and PFTs from the pulmonary function lab in the morning. Will also try to monitor his O_2 sat overnight with strip chart recorder as a screen for obstructive sleep apnea. Defer assessment of his pulmonary risk for coronary artery bypass graft until these studies [are] back, but my initial impression is that he would be an acceptable risk from a lung standpoint. I discussed with Dr. Towne.

EX 2.

Dr. Jamal Isber examined the Claimant on August 16, 2000, in consultation, regarding "Renal insufficiency." DX 24. Under the "Past Medical History" and "Surgical History portions of the consultation report, Dr. Isber stated that the Claimant had undergone coronary artery bypass graft surgery times 5 vessels. The date of the surgery is misstated as "January 1900." The reported clinical data, included a chest x-ray which "showed no CHF or infiltrate," and an EKG which "showed atrial fibrillation with incomplete right bundle branch block." In conclusion, Dr. Isber listed the following conditions:

> IMPRESSION:
> 1. Acute on chronic renal insufficiency.
> 2. Acute on chronic gout with multiple gout arthritis involving the right elbow, knees, ankles and toes.
> 3. COUMADIN toxicity.

4. Chronic atrial fibrillation.
5. Compensated CHF.
6. CAD, S/P CABG times 5 vessels.
7. Left carotid bruit.

DX 24.

Dr. Hudson reexamined the Claimant on June 12, 2001, in conjunction with the Claimant's black lung claim. On a U.S. Department of Labor report form, DX 11, Dr. Hudson set forth the Claimant's occupational, social, family and medical histories, and stated his findings on physical examination, chest x-ray, pulmonary function test, and arterial blood gas study. In pertinent part, Dr. Hudson reported a 25-year coal mine employment, 10 years of which were spend doing underground work, from 1950 to 1986. He noted that the Claimant "Operated Coal Tipple – Dug Coal." DX 11, Sec. B. Since leaving the coal mines in 1986, the Claimant worked odd jobs until 1990, when he last worked. DX 11, Sec. C. In addition, Dr. Hudson noted that the Claimant had "Never Smoked." DX 11, C3. Dr. Hudson also reported the Claimant's complaints of sputum, wheezing, dyspnea, cough, orthopnea, ankle edema, and paroxysmal nocturnal dyspnea. DX 11, Sec. D1. Furthermore, Dr. Hudson discussed various clinical test results, which were conducted on June 12, 2001, in the "Summary of Results" section of the form report, as follows:

Chest X-ray:	Neg for CWP. Bilateral pl. effusions
Vent Study (PFS)	FEV1 1.03 (34% pred)
Arterial Blood Gas	Resting pO2 73 pCO2 40
	Exercise pO2 86 pCO2 40
Other - EKG	A fib, incomplete RBB

DX 11, Sec. D5.

Under the Cardiopulmonary Diagnoses section of the U.S. Department of Labor form report, Dr. Hudson set forth the following diagnosis and underlying bases for such finding: Arteriosclerotic heart disease (ASHD) with congestive heart failure (CHF) based upon history of coronary artery bypass graft, extensive edema on exam, and chest x-ray consistent with CHF. When asked the etiology of the foregoing condition, he reported "ASHD – See above." DX 11, Sec. D7. In response to a form question regarding the severity of the Claimant's impairment from a chronic respiratory or pulmonary disease, if any, particularly in terms of the Claimant's ability to perform his last usual coal mine job, Dr. Hudson stated: "Totally impaired for all employment." DX 11, Sec. D8a. Dr. Hudson also noted "obesity" and "sleep apnea" as non-cardiopulmonary diagnoses which may affect the Claimant's ability to perform his coal mine work. DX 11, Sec. 8b.

On November 2, 2001, Dr. Abdul K. Dahhan, a B-reader who is Board-certified in Internal Medicine and Pulmonary Medicine, examined the Claimant. EX 1. In his report, dated November 5, 2001, EX 1, Dr. Dahhan set forth a 25-year coal mine employment history ending in 1986, of which 8 years were spent underground operating various machinery. He noted that the Claimant's last coal mine work was spent outside on the tipple. Dr. Dahhan also reported a

nonsmoking history, history of daily cough with productive clear sputum, intermittent wheeze, and use of Combivent inhaler four times daily. The Claimant also reportedly has a history of coronary artery disease, "heart attack three years ago" (*i.e.,* 1998) and coronary bypass surgery in 1999. The Claimant takes Coumadin, Norvasc, and Klonidine. On physical examination of the chest, Dr. Dahhan reported "midsternal scar with good air entry to both lungs. No crepitation or wheeze." An electrocardiogram showed "left ventricular hypertrophy with incomplete left bundle branch block." Arterial blood gas results at rest showed "normal values." The Claimant reportedly "declined an exercise study because of his heart condition." Dr. Dahhan also set forth the results of spirometry, lung volume measurements, total lung capacity, and diffusion capacity. The spirometry results, in particular were severely reduced both before and after bronchodilator. Furthermore, Dr. Dahhan found no parenchymal or pleural abnormalities consistent with pneumoconiosis on chest x-ray, but noted several other abnormalities, namely, "cardiac enlargement with right pleural effusion and post mediastinotomy as well as bilateral congestion." In addition, Dr. Dahhan's report contains a review of other medical data. In summary, Dr. Dahhan stated:

> In conclusion, based on my examination of Mr. Pyles and my review of his medical records as described above, within a reasonable degree of medical certainty, the following conclusions can be made:
>
> 1. Mr. Pyles is in congestive heart failure as documented by the orthopnea, dyspnea on exertion and edema as well as the finding of cardiac enlargement, pleural effusion and pulmonary congestion on the chest x-ray and the finding of an abnormality in the pulmonary function studies consistent with patients (sic) congestive heart failure.
>
> 2. Mr. Pyles has no radiological data to indicate the presence of coal workers' pneumoconiosis. Prior to his development of congestive heart failure, he had no physiological evidence on his pulmonary function studies to indicate the presence of coal workers' pneumoconiosis.
>
> 3. It might be appropriate to re-evaluate Mr. Pyles after his congestive heart failure has been treated and corrected to determine any primary pulmonary problem that he may suffer from.
>
> 4. Mr. Pyles suffers from obesity, sleep apnea and a vertical hernia. All are contributing to his respiratory impairment and restrictive ventilatory defect in addition to his congestive heart failure.
>
> 5. Mr. Pyles has coronary artery disease post bypass surgery, gout, obesity, sleep apnea and vertical hernia. All are conditions of the general public at large and are not caused by, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.
>
> 6. Mr. Pyles has total and permanent disability due to the multiple medical conditions that he suffers from as described above. However, none of these

> conditions have (sic) caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

EX 1, p. 4.

The record contains Dr. Lee J. Seargeant's office notes regarding his treatment of the Claimant during the period covering August 28, 2001 through January 21, 2002. DX 24. During the above-stated period, Dr. Seargeant treated the Claimant for multiple health problems and set forth numerous conditions including: renal failure, ASHD with auricular fibrillation, gouty arthritis, HCVD, ASHD, obesity, previous CHF, auricular fibrillation with a controlled ventricular response, chronic pyleonephrititis, and kidney failure. Noticeable by its absence is any reference to pulmonary disease and/or coal worker's pneumoconiosis. DX 24.

The case file also includes the reports and office notes of Kellie Brooks, a Board-certified Family Nurse Practitioner, dated June 3, 2002 and November 24, 2003, respectively. CX 6. On June 3, 2002, Ms. Brooks reported that the Claimant had a 32-year coal mine employment history which ended in 1988 "due to shortness of breath and breathing problems." Ms. Brooks also stated that the Claimant worked on the coal tipple, and "was exposed to a lot of coal dust and rock dust and did not have any respiratory protection." In addition, she noted the Claimant's complaints of productive cough, wheezing, two-pillow orthopnea with paroxysmal nocturnal dyspnea, and shortness of breath upon minimal activities. Under the heading "Past Medical History," Ms. Kelly stated the following: "Coal workers pneumoconiosis by chest x-ray. Coal miner for 32 years. COPD. Hypertension. S/P stroke in 1990. S/P with CABG in 1989. Hypothyroidism. Gout and arthritis." Under "Social History," Ms. Brooks reported that the Claimant does not smoke. Under "Review of Systems," she included, in pertinent part, "PULMONARY: Chronic cough, wheezing, short of breath on exertion, and orthopnea." In summary, Ms. Brooks listed coal workers pneumoconiosis and COPD under "Assessment," and the Claimant was reportedly to be followed by the Respiratory Care Center. CX 1. On November 24, 2003, Ms. Brooks reiterated the Claimant's subjective respiratory complaints and noted various abnormalities on inspection, percussion, and auscultation of the chest. Under "Assessment," Ms. Brooks listed coal workers pneumoconiosis. CX 6.

Dr. Dahhan reexamined the Claimant on October 20, 2003 and issued a report, dated November 10, 2003. EX 10. In this report, Dr. Dahhan stated that Mr. Pyles "claims to have worked in the mining industry for 30 years ending at age 55. He worked for five years underground loading and the rest was outside on the tipple." Dr. Dahhan also described the Claimant as a nonsmoker, who has a history of daily cough with productive clear sputum and intermittent wheeze, on Combivent inhaler as needed. Dr. Dahhan re-stated the medical history which he had set forth in his earlier report. On chest examination, Dr. Dahhan noted a "midsternal scar with no crepitation or wheeze." Electrocardiogram showed a pattern of atrial fibrillation with left bundle branch block. Arterial blood gases showed mild hypoxemia. The Claimant declined an exercise study. Spirometry results were severely reduced. Dr. Dahhan cited Dr. Wheeler's x-ray rereading, which was negative for pneumoconiosis, but showed cardiac enlargement, post bypass surgery and pleural effusion. Following his further review of other medical evidence, Dr. Dahhan stated:

In conclusion, based on my examination of Mr. Pyles and my review of his medical records as described above, within a reasonable degree of medical certainty, the following conclusions can be made:

1. There are insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis based on the normal clinical examination of the chest, negative chest x-ray and abnormality on pulmonary function studies that has resulted from other causes.

2. Mr. Pyles has a moderately severe respiratory impairment, which has resulted from his congestive heart failure as demonstrated by the markedly abnormal chest x-ray with cardiac enlargement, pulmonary congestion and pleural effusion. In addition, he has morbid obesity with a combination of the two elements that have resulted in a severe disabling respiratory impairment.

3. From a respiratory standpoint, Mr. Pyles doe not retain the physiological capacity to continue his previous coal mining work or job of comparable physical demand.

4. I find no evidence of pulmonary impairment and/or disability caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis since his congestive heart failure has resulted from his coronary artery disease and persistent cardiac arrhythmia and is contributed by his obesity. None of these conditions are caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

EX 10, p. 4.

The medical opinion evidence submitted in conjunction with the February 12, 1987 claim includes the opinions of Drs. Seargeant, Parrish, and Hudson.[7]

Dr. L.J. Seargeant examined the Claimant on February 25, 1987 and January 29, 1988, respectively. In his initial report, dated February 25, 1987, based on an examination performed for the Department of Labor, Dr. Seargeant listed the following cardiopulmonary diagnoses: 1. HCVD (*i.e.,* hypertensive cardiovascular disease) and, 2. Pneumoconiosis. In addition, Dr. Seargeant checked the "Yes" box in response to the following form question: "In your opinion is the diagnosed condition related to coal dust exposure in the patient's coal mine employment?" When asked to provide a medical rationale for his answer, Dr. Seargeant noted: "Refer to chest x-ray report as this is the basis of the pneumoconiosis diagnosis. Since the patient had never smoked, believe radiological changes most likely due to occupational hazards in and around mines. Do not believe HCVD was caused by occupation." DX 1 (DX 8). Following his reexamination of the Claimant on January 11, 1988, Dr. Seargeant issued a report, dated January

[7] In his Decision and Order Denying Benefits, dated November 23, 1988, Judge Thomas also discussed a consultation report by Dr. Obenour, dated March 10, 1988. However, as stated in the Decision and Order on Reconsideration, dated December 22, 1988, Dr. Obenour's report should not have been included, since it actually refers to a different claimant. DX 1.

29, 1988, in which he apparently relied upon Dr. Cohen's questionable x-ray finding of possible pneumoconiosis. In summary, Dr. Seargeant stated:

> Both examinations (*i.e.,* February 25, 1987 and January 11, 1988) revealed evidence of hypertensive cardiovascular disease, exogenous obesity, and chronic obstructive pulmonary disease with associated possible pneumoconiosis.
>
> His chest x-ray on 1/11/88 revealed evidence of possible pneumoconiosis. His hypertension has been treated by me and is responding favorably.
>
> According to the history, this patient has never smoked, but has been exposed to coal dust in and around the mines for at least 7 years and possibly longer.
>
> The chest x-ray changes are the basis for the diagnoses of chronic obstructive pulmonary disease and pneumoconiosis.
>
> In my opinion, these diagnoses coupled with the patient's age (57) are enough to warrant complete and permanent disability, especially for any further coal mine employment.

DX 1 (CX 1).

Dr. Richard E. Parrish examined the Claimant on July 5, 1987. In his report, dated July 21, 1987, Dr. Parrish reviewed various records and analyzed clinical data and findings on physical examination, including a pulmonary profile based on a Bruce protocol performed on July 14, 1987, during which his oxygenation improved with exercise. Pulmonary function tests could not be interpreted due to inadequate effort. Based upon the foregoing, Dr. Parrish stated, in pertinent part:

> I can find no evidence of pulmonary impairment in this gentleman. He does have radiographic abnormalities that may be related to coal workers pneumoconiosis though pleural thickening most commonly is related to asbestos exposure, if indeed it is related to an occupational exposure at all.

DX 1 (EX 1).

Dr. A.R. Hudson, Jr., examined the Claimant on March 7, 1988, on behalf of the Employer, for an evaluation for possible coal workers pneumoconiosis. In his report on that date, Dr. Hudson set forth the Claimant's present illness, review of systems, past medical history, habits, and occupational history, as well as findings on physical examination. In addition, Dr. Hudson reported the results of clinical tests. Based upon the foregoing, Dr. Hudson stated:

> Impression
>
> 1. Minimal chronic obstructive bronchitis without significant pulmonary impairment.
> 2. Obesity.
> 3. History of hypertension.

Summary:
This patient's chronic bronchitis is probably attributable to his mining exposure. His degree of dyspnea is markedly out of proportion to the objective measurements of pulmonary function. I do not find evidence of any significant pulmonary impairment. From the pulmonary standpoint alone he should be capable of all types of work. I suspect obesity is a major cause of his impairment. I do not find evidence to establish a diagnosis of coal workers pneumoconiosis.

DX 1 (EX 3).

Total Pulmonary or Respiratory Disability

The regulations provide that a claimant can establish total disability by showing the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his or her usual coal mine work, and from engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time. *See* 20 C.F.R. §718.204(b)(1). Where, as here, complicated pneumoconiosis is not established, total disability may be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. *See* 20 C.F.R. §718.204(b)(2)(i)-(iv).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979).

None of the arterial blood gas studies, old or new, are qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix C. Therefore, the Claimant has not established total disability pursuant to §718.204(b)(2)(ii).

Although the record shows that the Claimant has suffered from various heart problems, such as congestive heart failure, coronary artery disease, and atrial fibrillation, the evidence does not establish the presence of cor pulmonale with right-sided heart failure. Accordingly, the Claimant has failed to establish total disability pursuant §718.204(b)(2)(iii).

None of older pulmonary function studies through August 13, 1990 were qualifying. On the other hand, the more recent pulmonary function tests are qualifying under the standards stated in Part 718, Appendix B. In the Employer's Closing Argument, counsel argues that several of the qualifying pulmonary function studies were found to be invalid upon review, and that the "valid PFT's in the record show claimant does not have a disabling pulmonary impairment." (Employer's Closing Argument, p. 5). However, I find the Employer's argument unpersuasive for several reasons. First, I note that Dr. Michos, a Board-certified pulmonary specialist, reviewed the qualifying pulmonary function study performed June 12, 2001, and found it to be technically acceptable, notwithstanding suboptimal MVV performance. DX 11. The June 12, 2001, study is qualifying based upon the FEV1 and FVC values. Thus, the suboptimal MVV is inconsequential. Drs. Castle and Long, who are also Board-certified pulmonary specialists, questioned the validity of December 13, 2001 study. EX 4, 5. Furthermore, Dr. Long also challenged the validity of the October 20, 2003 pulmonary function test, which was administered at Stone Mountain Health Services. EX 11; *see* CX 4. However, no one questioned the validity of the October 20, 2003, pulmonary function tests, which were administered by Dr. Dahhan. EX 10. Furthermore, Dr. Dahhan's report specifies "Good" cooperation and comprehension and is in substantial compliance with the applicable quality standards set forth in §718.103. Thus I find that the more recent pulmonary function evidence clearly establishes the presence of a totally disabling pulmonary or respiratory impairment. Moreover, in view of the progressive nature of pneumoconiosis, I accord greater weight to the more recent pulmonary function studies. Therefore, I find that the Claimant has established total disability under §718.204(b)(2)(i).

In addition, I credit the early opinions of Drs. Parrish and Hudson over that of Dr. Seargeant regarding the total disability issue, since their opinions regarding the absence of any significant pulmonary impairment were more consistent with the objective clinical data obtained in conjunction with the initial claim. Thus the better reasoned medical opinion evidence in the prior claim did not establish the presence of a total pulmonary or respiratory disability. On the other hand, the more probative, recent medical opinion evidence, in particular Dr. Dahhan's opinion, which I credit, also establishes that the Claimant suffers from a totally disabling pulmonary impairment. Therefore, I find that the Claimant has established total disability under §718.204(b)(2)(iv), as well as (b)(2)(i).

As the Claimant has established that he has a totally disabling pulmonary impairment, he has also demonstrated a change in conditions since his previous claim was denied, as required by 20 CFR § 725.309.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2005).

20 CFR § 718.202(a) (2005) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Except for Dr. Cohen's equivocal descriptive finding of possible occupational lung disease, asbestosis, or pneumoconiosis on x-rays dated February 25, 1987, and January 11, 1988, virtually all of the interpretations of multiple chest x-rays found in the prior claim, taken between February 25, 1987, and March 7, 1988, are negative for pneumoconiosis, including all those rendered by dually-qualified B-readers and Board-certified radiologists. The record for the subsequent claim contains readings of more recent chest x-rays, dated June 12, 2001, November

2, 2001, April 8, 2002, April 18, 2002, and October 20, 2003. In every case in the subsequent claim, the x-ray readings are in equipoise, each having been read by the same number of physicians, and each having been read as both positive and negative. Except for Dr. Hudson, all of the physicians who read the more recent x-rays are B-readers. While Dr. Dahhan lacks Board-certification in radiology, he is a B-reader and Board-certified pulmonary specialist, EX 1. Although Dr. Pathak is not Board-certified by the American Board of Radiology, his curriculum vitae indicates that he is not only a B-reader but also that he has the British equivalent of Board-certification in radiology. DX 23. Furthermore, Drs. Cappiello, Ahmed, Pathak, Alexander, Scott, Scatarige, and Wheeler are all dually-qualified B-readers.

Since the record contains multiple conflicting interpretations of various films, including the most recent, by similarly well-qualified B-readers and/or Board-certified radiologists, I find that the x-ray evidence neither precludes nor establishes the presence of pneumoconiosis.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation,

other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2005). The Sixth Circuit has interpreted this rule to mean that

> in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

Eastover Mining Co. v. Williams, 338 F.3d 501, 513 (6th Cir. 2003) (citations omitted).

The medical opinion evidence submitted in the prior claim is insufficient to establish pneumoconiosis under §718.202(a)(4). In making this determination, I find that Dr. Seargeant's finding of "possible" pneumoconiosis was equivocal and that it was based upon Dr. Cohen's questionable positive x-ray interpretation. Dr. Parrish also cited radiographic abnormalities, while finding no evidence of pulmonary impairment. Finally, Dr. Hudson's finding that the Claimant's chronic bronchitis is "probably attributable to his mining exposure" is also too equivocal to establish "legal pneumoconiosis."

As summarized above, the case file includes the recent medical opinions and/or office notes of Drs. Poteet, EX 8, Toyohara, EX 3, Hudson, EX 2, DX 11, Isber, DX 24, Dahhan, EX 1, 10, Seargeant, DX 24, and Kellie Brooks, a Family Nurse Practitioner, CX 6, which were submitted in connection with the current, subsequent claim.

Of the foregoing, only Ms. Brooks, a Nurse Practitioner reported a diagnosis of pneumoconiosis. However, I accord Ms. Brooks less weight, since she lacks the medical credentials of the physicians of record, in particular, the opinion of Dr. Dahhan, a Board-certified pulmonary specialist. Furthermore, I note that Ms. Brooks appears to have relied primarily upon the Claimant's history and subjective complaints. However, Ms. Brooks reported that the Claimant engaged in coal mine employment history for 32 years until 1988, and that Mr. Pyles did not have any respiratory protection in the mines. CX 6. In fact, the Claimant alleged, alternatively, 22, 25, and 30 years of coal mine employment in 1986. DX 1,3; TR 14-15. Moreover, the Claimant testified that he did wear a respirator, and that most of his coal mine work was spent above ground, albeit in dusty conditions. TR 17-18. Accordingly, Ms. Brooks misstated the Claimant's mining history. Furthermore, Ms. Brooks failed to cite underlying objective clinical test results to support her finding of pneumoconiosis. CX 6. In view of the foregoing, I do not find Ms. Brooks' opinion to be well-reasoned and/or well-documented.

Dr. Poteet's opinion, in pertinent part, cites the Claimant's complaints of various breathing problems and cites a mild obstructive pattern on pulmonary function testing. However, Dr. Poteet relates these conditions to morbid obesity and possible "Pickwickian" syndrome. Accordingly, Dr. Poteet's opinion does not support the Claimant's claim for black lung benefits. I note, however, that Dr. Poteet's report was issued in 1990. In view of the progressive nature of pneumoconiosis, I accord his opinion less weight. The reports of Drs. Toyohara, EX 3, and Isber, DX 24, do not directly address the pneumoconiosis issue. However,

they confirm that the Claimant has suffered from serious heart problems and renal insufficiency in 1999 and 2000, and that he underwent quintuple coronary artery bypass graft surgery. Dr. Hudson conducted a preoperative pulmonary evaluation of the Claimant in December 1999, EX 2, and reexamined him on June 12, 2001, in conjunction with the current claim, DX 11. Although Dr. Hudson found that the Claimant is totally disabled, he did not relate such disability to pneumoconiosis. To the contrary, Dr. Hudson did not diagnose pneumoconiosis or any other coal mine-related disease in either of his recent reports, but cited the Claimant's cardiac conditions, as well as obesity and sleep apnea. Dr. Seargeant's recent notes make no mention of pneumoconiosis or any other occupationally related disease. On the other hand, Dr. Seargeant diagnosed renal failure and multiple heart conditions. DX 24.

I find Dr. Dahhan's opinion to be most persuasive. EX 1, 10. In making this determination, I first note that Dr. Dahhan is a B-reader and Board-certified pulmonary specialist. More importantly, I find that Dr. Dahhan's opinion is well-reasoned and well-documented and most consistent with the Claimant's history and the credible, objective medical data. Even though the Claimant worked as a coal miner for 23 or more years, only a few of the years were spent in underground mining. Furthermore, the Claimant wore a respirator during his coal mine work. Although the x-ray evidence is inconclusive regarding the pneumoconiosis issue, the record clearly establishes that several years after the Claimant left the coal mines, he still retained the respiratory and pulmonary capacity to perform his last usual coal mine job. However, in the interim between 1990 and 2001, the Claimant's respiratory condition worsened dramatically. While I note that pneumoconiosis is a latent disease which can manifest itself even without further exposure to coal mine dust, no physician of record has attributed this severe deterioration to pneumoconiosis. To the contrary, the physicians of record, including Dr. Dahhan, cite the Claimant's numerous non-occupational health problems, such as congestive heart failure, coronary artery disease, cardiac arrhythmia, and obesity, which are borne out by the recent treatment notes and medical records. Accordingly, I credit Dr. Dahhan's opinion that the Claimant suffers from a totally disabling respiratory impairment, but that such condition is unrelated to pneumoconiosis and/or coal dust inhalation. Therefore, I find that the Claimant has not established pneumoconiosis under §718.202(a)(4), or by any other means.

I have also weighed all the relevant evidence together under 20 C.F.R. §718.202(a) to determine whether the miner has established (clinical or legal) pneumoconiosis. In summary, the older x-ray evidence was overwhelmingly negative for pneumoconiosis. On the other hand, the more recent x-ray evidence neither precludes nor establishes the presence of simple pneumoconiosis. Although the recent x-ray evidence is more probative in view of the progressive nature of pneumoconiosis, the Claimant has still not met his burden of establishing pneumoconiosis. As outlined above, I find that the older medical opinion evidence was inconclusive regarding the pneumoconiosis issue. On the other hand, the better reasoned recent medical opinion evidence states that the Claimant does not suffer from "clinical" or " legal" pneumoconiosis. In view of the foregoing, I find that the presence of pneumoconiosis has not been established under 20 C.F.R. §718.202(a). *Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000); *see also, Penn Allegheny Coal Co. v. Williams,* 114 F. 3d 22 (3d Cir. 1997).

Neither the x-ray evidence, nor the medical opinion evidence, weighed separately or together, is sufficient to establish the existence of pneumoconiosis. Nor has the Claimant shown its presence by any other means. I find that the Claimant has failed to meet his burden of showing that he has a pulmonary or respiratory disease attributable to his exposure to coal dust. Thus he cannot show that he is entitled to benefits under the Act.

Causation of Total Disability

Since the Claimant has failed to establish that he suffers from pneumoconiosis, he clearly cannot establish total disability due to pneumoconiosis. 20 C.F.R. §718.204(c). In his oral argument at the close of the hearing, the Claimant's lay representative cited the Claimant's coal mine employment history of at least 23 years, some positive chest x-ray interpretations by B-readers, qualifying pulmonary function studies, and Dr. Dahhan's opinion. TR 24-25. None of the foregoing establish total disability *due to pneumoconiosis* as required under §718.204(c). For the reasons discussed above, I credit Dr. Dahhan's opinion, in which he found that the Claimant's severe disabling respiratory impairment is unrelated to pneumoconiosis and/or inhalation of coal dust.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that his total pulmonary disability is caused by coal workers' pneumoconiosis, he is not entitled to benefits under the Act.

REPRESENTATIVE'S FEES

The award of a representative's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The request for modification filed by Horace M. Pyles on March 12, 2003, is hereby DENIED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of

Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).